Refugee Health Assessment Form

Please submit this form within 30-45 days after its completion to the
VDH Division of Disease Prevention, Newcomer Health Program
PO Box 2448, Richmond, VA 23218

Name (Last, First, MI): _____ , _____ _____ **US Arrival Date:** _____

Alien Reg #: A _____ **File #:** _____ **Gender:** _____ **DOB:** _____ **TB Status:** _____

Country of Origin: _____ **VOLAG:** _____

Country of Exit: _____ **Dist. Mailed To:** _____ **Date Mailed:** _____

THE HEALTH DISTRICT PROVIDING THE HEALTH ASSESSMENT COMPLETES THIS PORTION OF FORM

Was the Refugee Located? (Circle one): Yes No → If **Not Located**, provide reason if known: _____

↓

If the Refugee was not located, you cannot complete this assessment.
Return this form to VDH Newcomer Health Program (see address above).

If the refugee was located, provide the name of the **Health District** providing this health assessment: _____

Person Completing This Form: _____
Phone #: (_____) _____ Date of Assessment: _____/_____/_____

Your Health District must decide whether or not to bill Medicaid for this initial refugee health assessment. Forms received without checking YES *or* NO (see below) will be returned, delaying compensation.

☐ YES: Check here if your **district INTENDS** to bill the refugee's Medicaid for elements included in this Health Assessment. By checking here, the health district indicates it will accept the Medicaid reimbursement allowance for elements within this health assessment. Your district will **not** be reimbursed by DSS administered Refugee Medical Assistance Funds.

☐ NO: Check here if your **district DOES NOT INTEND** to bill Medicaid for elements in this Health Assessment. By checking here, the health district indicates that for this health assessment it will accept the reimbursement from DSS administered Refugee Medical Assistance Funds, facilitated by DTC. Further, the district agrees **not** to bill the refugee's Medicaid for *any* element included in this initial health assessment. Subsequent health visits can and should be billed to the refugee's Medicaid or other medical insurance.

LEVEL I: REQUIRED MINIMUM, ASSESSMENT FOR TUBERCULOSIS DISEASE/INFECTION

(May be completed by PHN, NP, PA, or MD) **(Level I only = $116.00)**

Each item requires a response.

Mantoux Skin Test Reaction
- ☐ Negative
- ☐ Positive
- ☐ Given, not read
- ☐ Not done, explain: _____

Chest X-ray (in US) if PPD + &/or S/S
- ☐ Normal (not TB)
- ☐ Abnormal (TB suspected)
- ☐ N/A (negative PPD & no S/S of TB)

Therapy (if indicated)
- ☐ TX for suspected or confirmed TB disease considered
- ☐ Therapy for LTBI indicated
- ☐ Based on evaluation, no therapy indicated now

1. What is the refugee's *primary language* (other than English)? _____

(Circle one)

2. Was an interpreter *necessary* to conduct this refugee's health history and assessment? .... Yes No

(If Yes, circle the source listed in the box below. If No, skip to Level II)

1. Voluntary Agency Interpreter
2. LHD Trained Staff Interpreter
3. LHD Bilingual Staff
4. Language Line Services
5. Contract Interpreter
6. Other _____

LEVEL II: HEALTH HISTORY AND ASSESSMENT (May be completed by PHN, NP, PA, or MD*)*

(Level I and II = $271.00, if refugee is under the age of 11 years; $316.00 if refugee is 11 years of age or older)

To receive compensation for completing Level II, Level I assessment is required and ***each*** item in Level II requires a response**.**

Review of the refugee's health history and			(**Circle One)**
1) The gross inspection / assessment / systems review. Question for current health problems?	WNL?	Yes	No
2) A gross evaluation of vision and hearing (eye chart and whisper test)	WNL?	Yes	No
3) A gross dental inspection / assessment (gross inspection of the oral cavity)	WNL?	Yes	No
4) STD follow-up for any STD *if identified* on federal form DS 2053 or OF-157		Done	NA
5) Is this refugee's weight appropriate for his / her height?		Yes	No
6) Is this refugee's hemoglobin **& / or** hematocrit appropriate for his / her age & sex?		Yes	No
7) If 5 years old or over, is this refugee's Blood Pressure grossly within normal limits? (If age < 5, circle Yes)		Yes	No

8) Review the refugee's immunization history. Determine if his/her immunization status is current and to date for age. *Indicate if any update is necessary by checking yes / no to each item*. **You are encouraged to begin the update (give immunizations) during this visit and refer appropriately for follow up at your district immunization clinic.**

Immunization History	**(Circle One)**	
Diphtheria, Tetanus, and if indicated for age, Pertussis	Yes	No
Polio	Yes	No
Measles, Mumps, and/or Rubella	Yes	No
Hepatitis B (series requires referral to immunization clinic)	Yes	No
Haemophilus influenzae type B	Yes	No
Varicella	Yes	No
Pneumococcal (necessary if indicated by age or health condition)	Yes	No
Influenza? (Necessary if season, age, and /or health condition)	Yes	No

			(**Circle One)**	
9) Hepatitis B Screening: (Africa, Asia, Middle East; at times, former Soviet States & Eastern Europe)			Done	NA
10) Parasite screening: (Africa, Asia, Middle East, and if from a refugee camp)			Done	NA
11) **IF FEMALE**, is this refugee currently pregnant?			Yes	No Male
12) General mental status assessment (orientation to person, place, time, as age appropriate)?	WNL?		Yes	No

LEVEL III: EXPANDED HEALTH ASSESSMENT (A PHN, NP, PA, or MD may complete this portion)

(Level I, II, and III = $294.00 if refugee is under the age of 11 years; $339.00 if refugee is 11 years of age or older)

To receive compensation for completing Level III, completion of Levels I and II are required and sections specific to the refugee's age require responses.

			(Circle one)	
1)	An assessment *that at a minimum includes listening to heart & lung sounds.* A diagnosis is not necessary, but if sounds are abnormal a referral is necessary in Level IV		Done	Not Done
2)	Age specific recommended screening:			
	a) **Age <5 years**:			
	1. Measure of head circumference	WNL?	Yes	No
	2. Assess developmental milestones	WNL?	Yes	No
	b) **Age 5-15 years**:			
	1. Provide nutritional assessment (if ht & wt <5th%)		Done	NA
	2. Assess developmental level / mental status	WNL?	Yes	No
	c) **Age >15 years:**			
	1. Evaluate further if weight is more than 10% under normal range ***OR*** If weight is more than 40% over normal range		Done	NA
	2. Evaluate for hypertension if BP elevated		Done	NA
	3. CBC, platelets, if hematocrit less than 30%		Done	NA
	4. VDRL if indicated by history or abnormal exam		Done	NA
	5. Offer HIV testing if indicated by history or abnormal exam		Done	NA
	d) **Age >46 years or if indicated at any age**:			
	1. Stool exam for blood (hemoccult)		Done	NA
	2. Fasting glucose		Done	NA
3)	Fasting cholesterol		Done	NA
4)	Cancer information and / or evaluation as appropriate.		Done	NA

LEVEL IV: PUBLIC HEALTH NURSE CASE MANAGEMENT
Includes any referrals as necessary based on health assessment.

This Level is reimbursed *once* @ $115.00, regardless of the number of referrals. Make sure the referral corresponds to findings as documented in the previous Levels. If not, the referral will not be counted.

		(Circle one)	
1)	Referral for consideration of therapy for TB infection or disease?	Yes	No
2)	Referral for abnormal vision finding?	Yes	No
3)	Referral for abnormal hearing finding?	Yes	No
4)	Referral following a **normal** dental inspection?	Yes	No
5)	Referral for follow-up due to an **abnormal** dental inspection?	Yes	No
6)	Referral necessary for an STD/HIV finding?	Yes	No
7)	Referral necessary for abnormal weight finding?	Yes	No
8)	Referrals necessary for anemia / malaria findings?	Yes	No
9)	Referral necessary to update immunizations per ACIP guidelines?	Yes	No
10)	Referral necessary for Hepatitis B?	Yes	No
11)	Household contact testing for Hepatitis B necessary?	Yes	No
12)	Referral required for abnormal parasite screening?	Yes	No
13)	Referral necessary for developmental delays?	Yes	No
14)	Referral necessary for mental health evaluation?	Yes	No
15)	Referral for any other problems identified at health assessment?	Yes	No

This form serves as both an invoice tool and health data collection tool, please complete appropriately and accurately. The program can reimburse Health Districts only. The program cannot reimburse private physicians or non-public health department clinics. However, a health district may choose to contract with a health provider to provide the health assessment. The district then accepts responsibility for reimbursing their contractor.

PLEASE RETURN THIS FORM TO VDH/NHP AS SOON AS POSSIBLE AFTER THE HEALTH ASSESSMENT IS COMPLETE.

Reimbursement Can Only Be Made With Proper Documentation

NOTE: Forms received more than one year after the health assessment date will be returned; and, the district will not be paid for the services.

Questions?
Telephone number: (804) 864-7910
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